Travis County Benefits
Definition of Qualified Change in Status and Instructions for Completing This Form

Step 1: Employee Information

Please complete each line in full. You must provide at last one phone number where you can be reached during regular business hours.

Step 2: Reason for Enrollment/Change (You must meet the following eligibility requirement)

Date of Event: You have 30 days from the date of the Qualified Change in Status to make the change.
You must have supporting documents to verify the eligibility of your dependent to enroll.

THE FOLLOWING IS A LIST OF QUALIFIED CHANGE IN STATUS

ADDING DEPENDENTS

- Employee's marriage or divorce or death of employee's spouse
- Birth, adoption or death of a dependent child
- Significant employer- or carrier-initiated changes in or cancellation of the employee's, spouse's or dependent child's coverage
- Change in employee's, spouse's or dependent child's employment status that affects benefit
- Eligibility, such as leave without pay, benefit eligibility with spouse's current employer

TERMINATING DEPENDENTS

- Child becoming ineligible for coverage due to reaching age 26
- Changes in the employee's, spouse's or a dependent child's residence that would affect eligibility for coverage
- Employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child
- Changes made by a spouse or dependent child during his/her annual benefit/insurance enrollment period with another employer
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid
- Change in day care costs due to a change in provider, change in provider's fees (if the provider is not a relative) or change in the number of hours the child needs day care (for Dependent Day Care Spending Accounts)
- The employee or dependent child loses coverage under the state Medicaid or child health plan or becomes eligible for premium assistance under the Medicaid or child health plan (you have 60 days to notify us of the change if your child becomes eligible or not eligible for either Medicaid or CHP)
- **If your event meets one or more of the Qualified Change in Status definitions complete the form as instructed. If you are not sure contact Travis County Benefits at 512.854.0404**

Step 3: Medical/Dental/Vision/Dep Life/ Spouse Supplemental Life Election

Coverage Selections: Check the box for the type of coverage you are requesting for Medical, Dental, Vision, Dependent Life Insurance and/or Spouse Supplemental Life. If you are adding a dependent to existing Medical or Dental coverage you must continue with the same plan option. If you are dropping a dependent and would like to change plans select the new plan and list the dependent information in the dependents box. Also notate at the top of the form that you are changing plans.

Flex Accounts: If you have an existing Unreimbursed Medical or Dependent Care Account and would like to request a change to the amount based on a Qualified Change in Status, fill in your current annual election and your new annual election amount. If you are enrolling in one of the two plans for the first time, enter "$0" in the current annual election and your new annual election amount. Limited FSA is only eligible if enrolled in the HDHP with HSA.

Step 4: Dependent Information

Please complete each line in full for each dependent you are adding or dropping from coverage. If you are adding a dependent for the first time, documentation verifying the dependent status must be submitted to HRMD. Please refer to the "Chart of Characteristics and Documentation Required to Enroll a Dependent by Category" form located on Travis central for the list of dependent documentation requirements. ***Dependents will not be enrolled unless documentation has been submitted to HRMD.***

Step 5: Authorization

Read authorization statement and then sign and date form.

Travis County Benefits Change Form

Please complete this benefits change form if you have experienced a change in family status. Return the signed form to HR-Benefits by **FAX (512.854.6677)** or by email to BenefitsTeam@traviscountytx.gov within 30 days of the event. Please contact Travis County Benefits by **PHONE (512.854.0404)** with any question about this form or your benefits.

Employee Information

Last Name:	First:	MI:	Social Security Number:			Employee ID Number:	
Home Address:			Date of Birth			Gender	
			MONTH	DAY	YEAR	☐ Male	☐ Female
City:	State:	Zip:	Home/Cell Phone:				
Department:	Email Address:		Work Phone:				

Reason for Enrollment/Change

Date of Event:____________________ (Documentation required for qualified events and adding dependents)

☐ Add coverage ☐ Marriage ☐ Extended Military Leave ☐ Divorce ☐ Gain other coverage
☐ Drop Coverage ☐ Birth/Adoption ☐ Loss of other coverage ☐ Death ☐ Dep no longer eligible for coverage
☐ Other:

Medical	Dental	Vision	Dep Life	Spouse Supp Life
☐ Decline	☐ Decline	☐ Decline	☐ Decline	☐ Decline
☐ EPO	☐ Basic PPO	☐ Davis Vision	☐ Dep Life	☐ $10,000
☐ PPO	☐ Preferred PPO			☐ $20,000
☐ Consumer Choice	☐ Prepaid DHMO			
☐ High Deductible w/HSA	☐ Preventive Only			
HSA Contribution $_________				

Flexible Spending Account Election

Current Health FSA Annual Election	$_______________	New Healthcare FSA Annual Election	$_______________
Current Dependent Care FSA Annual Election	$_______________	New Dependent FSA Annual Election	$_______________
Current Limited FSA Annual Election **(Only eligible with HDHP w/HSA)**	$_______________	New Limited FSA Annual Election	$_______________

Dependent Information

Name: *Last*	*First*	*MI*	Relationship	Gender	Date of Birth	SSN	Medical	Vision	Dental	Dep Life
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Authorization

I authorize Travis County to deduct required contribution (if any) from my earnings for coverage under the plans I have checked. I understand that knowingly providing false and/or misleading information may subject me to disciplinary and/or legal action and may result in loss of insurance coverage.

Signature: **Date:**